Appendix 3 - Management of Tongue-Tie in Early Infancy

TYPES OF TIE

Anterior Tie (Types I and II)

Posterior (submucosal) Tie (Types III and IV)

Frenotomy could be considered in healthy infants with a tongue-tie who present with a problem feeding.

All professionals agree that tongue-tie on its own without feeding problems does not necessarily require frenotomy.

Good lactation/feeding assessment is crucial to support babies with a tongue-tie.

It is uncertain whether anklyoglossia (tongue-tie) is a congenital oral anomaly or whether it is a normal variant.

A small number of mothers may experience breastfeeding difficulties. This has been attributed to apparent tongue tie in the infant, however many mothers experience no difficulty feeding infants with apparent tongue-tie, and infants with apparent tongue-tie generally have no difficulty bottle feeding.

Presenting problems attributed to tongue tie are nipple pain, poor latch, poor feeding, slow weight gain, unsettled infant. However these symptoms are also common in first time breast feeding mothers.

There are many assessment tools (e.g. Hazelbaker), many are very time consuming and of uncertain value. Assessment can be done using the right sidebar:

What to do if tongue tie is suspected:

- Confirm that tongue-tie is present; this should include a full examination of the palate.
- Obtain a lactation consultant assessment prior to any referral for possible tongue tie release procedure. Breastfeeding may be attributable to non tongue tie issues.
- Undertake an oral & systemic examination of the baby to exclude local causes such as cleft palate and systemic causes such as UTI, airway difficulties or cardiac problems.
- If the feeding problem persists, intervention at 2-3 weeks of age may be appropriate before feeding problems make breastfeeding so difficult that the mother stops feeding. If the tongue tie is very obvious and the feeding difficulties are severe intervention may be considered before this.
- Advice should be given on feeding in the interim by Lactation Consultant.
- Ascertain that the baby has been given Vitamin K, and there is no family history of blood dyscrasias.
- Referral by medical practitioner to an appropriately trained professional to assess severity of tongue tie and possible frenotomy.
  ('Tongue Tie Assessment Referral Form' - available at: https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/paediatrics-tongue-tie-in-early-infancy.pdf

Follow the baby and mother up after the frenotomy. If feeding does not improve there is another cause for the difficulties. Some babies who undergo frenotomy continue to have feeding problems despite releasing the tongue tie. Skilled breastfeeding advice and support is essential post procedure.

ASSESSMENT

1. Mother's symptoms:

- Nipple pain; persistent over one week's duration.
- Breast pain, mastitis, engorgement beyond normal initial feeding issues.
- Distorted nipple shape after feed, bleeding or ulcerated nipples.

2. Feeding history:

- Failure or likely failure to regain birth weight by 2-3 weeks of age.

3. Look at Latch:

- Is the infant's latch correct?
- Is latch being maintained?
- Check position of baby at breast.

4. Listen and look:

- Clicking sounds while feeding.
- Pooling milk around mouth during feeds.
- Gasping, struggling on the breast.
- Bobbing around, latch slips

5. Look and palpate:

- Extension (sticking out tongue), elevation (lift of the body of the tongue in the mouth, not just the tip - should reach at least halfway up to the palate) and lateralisation (side to side movement of the tongue - often better to one side with tongue tie).
- Frenulum extends anteriorly to tip of tongue or lower gum line (abnormal).
- No visible frenulum, but tight band palpable under the tongue, query posterior tie.